



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF DALLAS
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2679-01

MFDR Date Received

April 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was reimbursed; however, it was not processed according to the PPO accessed with the Beechstreet contract."

Amount in Dispute: \$10,383.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the preponderance of the information provided by the requestor does not support the terms of the PPO contract for the dates in dispute, no further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2010 to April 8, 2010	Outpatient Hospital Services	\$10,383.01	\$1,662.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
- 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.)
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 356 – THIS ALLOWANCE WAS BASED ON THE PART B FEE SCHEDULE AMOUNT
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 420 – SUPPLEMENTAL PAYMENT.
- 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 615 – PAYMENT FOR THIS SERVICE HAS BEEN REDUCED ACCORDING TO THE MEDICARE MULTIPLE SURGERY GUIDELINES.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/BEECH STREET. FOR PROVIDER SUPPORT 1-800-243-2336.
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – “CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY)” and 793 – “REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/BEECH STREET. FOR PROVIDER SUPPORT 1-800-243-2336.” The respondent’s position statement asserts that “Because the preponderance of the information provided by the requestor does not support the terms of the PPO contract for the dates in dispute, no further payment is due.” Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 13, 2013, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The contract submitted by the insurance carrier is in the name of a different insurance company or network than was referenced on the explanation of benefits. The name of the hospital on the contract is different from the name of the requestor. No documentation was found to support that the contract was in effect on the dates of service in dispute. No documentation was found to support that the respondent had been given access to the provider’s contractual fee arrangement with Beechstreet. No documentation was found to support a contractual fee arrangement with Beechstreet that was applicable to the dates of service in dispute. No documentation was found to support that the respondent had been given access to any contractual fee arrangement with the provider during the dates of service in dispute. The respondent submitted a client list for still another network than was referenced on the explanation of benefits. The client listing is dated March 20, 2013. No documentation was presented to support that the provider had been given notice that the respondent had been given access to any applicable contractual fee arrangement with the provider during the dates of service in dispute. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published

annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.14. 125% of this amount is \$13.93
 - Procedure code 70480 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0332, which, per OPPS Addendum A, has a payment rate of \$195.07. This amount multiplied by 60% yields an unadjusted labor-related amount of \$117.04. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$113.89. The non-labor related portion is 40% of the APC rate or \$78.03. The sum of the labor and non-labor related amounts is \$191.92. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$191.92 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.044979, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$88.65 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$191.92. This amount multiplied by 200% yields a MAR of \$383.84.
 - Procedure code 67036 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 66920 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 67040 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0672, which, per OPPS Addendum A, has a payment rate of \$2,693.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,616.30. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$1,572.82. The non-labor related portion is 40% of the APC rate

or \$1,077.53. The sum of the labor and non-labor related amounts is \$2,650.35. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$2,650.35 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.621148, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$1,224.28 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.292. This ratio multiplied by the billed charge of \$1,224.28 yields a cost of \$357.49. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$2,650.35 divided by the sum of all APC payments is 58.96%. The sum of all packaged costs is \$5,405.62. The allocated portion of packaged costs is \$3,186.97. This amount added to the service cost yields a total cost of \$3,544.46. The cost of these services exceeds the annual fixed-dollar threshold of \$2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$2,650.35. This amount multiplied by 200% yields a MAR of \$5,300.70.

- Procedure code 65235 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0233, which, per OPPS Addendum A, has a payment rate of \$1,095.25. This amount multiplied by 60% yields an unadjusted labor-related amount of \$657.15. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$639.47. The non-labor related portion is 40% of the APC rate or \$438.10. The sum of the labor and non-labor related amounts is \$1,077.57. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$538.79 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.126273, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$248.88 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$538.79. This amount multiplied by 200% yields a MAR of \$1,077.58.
- Procedure code 65275 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0234, which, per OPPS Addendum A, has a payment rate of \$1,644.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$986.91. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$960.36. The non-labor related portion is 40% of the APC rate or \$657.94. The sum of the labor and non-labor related amounts is \$1,618.30. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$809.15 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.189636, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$373.77 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$809.15. This amount multiplied by 200% yields a MAR of \$1,618.30.
- Procedure code G0384 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC

8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0630, which, per OPPS Addendum A, has a payment rate of \$232.32. This amount multiplied by 60% yields an unadjusted labor-related amount of \$139.39. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$135.64. The non-labor related portion is 40% of the APC rate or \$92.93. The sum of the labor and non-labor related amounts is \$228.57. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$228.57. This amount multiplied by 200% yields a MAR of \$457.14.

- Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.40. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$14.99. The non-labor related portion is 40% of the APC rate or \$10.27. The sum of the labor and non-labor related amounts is \$25.26. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$25.26 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.00592, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$11.67 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$25.26. This amount multiplied by 200% yields a MAR of \$50.52.
- Procedure code 96365 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96374 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96375 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96376 is unbundled. This procedure is a component service of procedure code 67040 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2550 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3470 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90714 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90732 has a status indicator of L, which denotes influenza and pneumococcal pneumonia vaccine, not paid under OPPS; paid at reasonable cost. The insurance carrier allowed \$45.95. Review of the submitted information finds insufficient documentation to support a different reimbursement amount from the amount determined by the carrier, therefore no additional payment is recommended.
 - Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$26.56. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.94. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$15.51. The non-labor related portion is 40% of the APC rate or \$10.62. The sum of the labor and non-labor related amounts is \$26.13. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$26.13 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.006124, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$12.07 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$26.13. This amount multiplied by 200% yields a MAR of \$52.26.
 - Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.40. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$14.99. The non-labor related portion is 40% of the APC rate or \$10.27. The sum of the labor and non-labor related amounts is \$25.26. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$25.26 divided by the sum of all S and T APC payments of \$4,266.86 gives an APC payment ratio for this line of 0.00592, multiplied by the sum of all S and T line charges of \$1,971.00, yields a new charge amount of \$11.67 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$25.26. This amount multiplied by 200% yields a MAR of \$50.52.
4. The total allowable reimbursement for the services in dispute is \$9,054.49. This amount less the amount previously paid by the insurance carrier of \$7,391.55 leaves an amount due to the requestor of \$1,662.94. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,662.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,662.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>May 10, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.